UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
x----------x
GILEAD SCIENCES, INC.,

Plaintiff,

-against-

ABRAHAM T. MORRISON,

Defendant.
x----------x

Case No. 08-CV-0566(DLC)(GWG)

DEFENDANT'S RESPONSE FOR AUTHORIZATIONS AND MEDICAL RECORDS

1. Defendant objects to such demand as it is neither material nor necessary to the prosecution or defense of instant action.

2. See attached herein authorizations for defendant's hospital and medical records.

3. Defendant is not in possession of any such records at this time.

4. Defendant is not in possession of any such records at this time.

Defendant reserves the right to amend said Response for Authorizations and Medical Records at a later time.

Dated: August 22, 2008
Forest Hills, NY

PAUL E. KERSON
Leavitt, Kerson & Duane
Attorneys for Defendant
118-35 Queens Blvd., Suite 1205
Forest Hills, NY 11375
(718) 793-8822

To: Carmine J. Castellano, Esq.
Bainton McCarthy LLC
Attorneys for Plaintiff
26 Broadway, Suite 2400
New York, NY 10004-1840
(212) 480-3500

STATE OF NEW YORK, COUNTY OF QUEENS ss.:

STACEY SHOWALTER, being duly sworn says: I am not a party to the action, am over 18 years of age and reside at Queens County.

On August 22, 2008, I served a true copy of the annexed DEFENDANT'S RESPONSE FOR AUTHORIZATIONS AND MEDICAL RECORDS

in the following manner:

☐ **Service By Mail** By mailing the same in a sealed envelope, with postage prepaid thereon, in a post-office or official depository of the U.S. Postal Service within the State of New York, addressed to the last known address of the addressee(s) as indicated below:

☐ **Personal Service on Individual** By delivering the same personally to the persons and at the addresses indicated below:

☐ **Service by Electronic Means** By transmitting the same to the attorney by electronic means to the telephone number or other station or other limitation designated by the attorney for that purpose. In doing so I received a signal from the equipment of the attorney indicating that the transmission was received, and mailed a copy of same to that attorney, in a sealed envelope, with postage prepaid thereon, in a post office or official depository of the U.S. Postal Service within the State of New York, addressed to the last known address of the addressee(s) as indicated below:

☐ **Overnight Delivery Service** By depositing the same with an overnight delivery service in a wrapper properly addressed. Said delivery was made prior to the latest time designated by the overnight delivery service for overnight delivery. The address and delivery service are indicated below:

Carmine J. Castellano, Esq.
Bainton McCarthy LLC
Attorneys for Plaintiff
26 Broadway, Suite 2400
New York, NY 10004-1840

Sworn to before me on August 22 , 2008

s/Paul E. Kerson
Notary Public

s/Stacey Showalter
STACEY SHOWALTER

Case No. 08-CV-0566 (DLC)(GWG)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

GILEAD SCIENCES, INC.,

Plaintiff,

-against-

ABRAHAM T. MORRISON,

Defendant.

DEFENDANT'S RESPONSE FOR AUTHORIZATIONS AND MEDICAL RECORDS

LEAVITT, KERSON & DUANE
Attorneys for Defendant
118-35 Queens Boulevard
Suite 1205
Forest Hills, New York 11375
(718) 793-8822
Fax (718) 261-5013

Pursuant to 22 NYCRR 130-1.1, the undersigned, an attorney admitted to practice in the courts of New York State, certified that, upon information and belief and reasonable inquiry, the contentions contained in the annexed document are not frivolous.

Dated: ..... Signature:.....

Print Signer's Name _____

Service of a copy of the within *is hereby admitted.*

Dated: .....
Attorney(s) for

LEAVITT, KERSON & DUANE
Attorneys for Defendant
118-35 Queens Blvd., #1205
Forest Hills, NY 11375
(718) 793-8822

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Abraham Morrison	8/18/1967	073-44-7923
Patient Address: **c/o Calvary Hospital, 1740 Eastchester Road, Room 642, Bronx, NY 10461**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Dr Tony Cheung, Mt. Sinai Hsp, 1 Gustave Levy Pl, NY NY 10029

8. Name and address of person(s) or category of person to whom this information will be sent:
Brinton McInerney LLP, 26 Bway, #2400, NY NY 10004

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- AM Alcohol/Drug Treatment
- AM Mental Health Information
- AM HIV-Related Information

Authorization to Discuss Health Information

(b) ☑ By initialing here AM (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:
Alexandra Mishail, Esq., and/or Paul E. Kerson, Esq., of the law offices of Leavitt, Kerson & Duane
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**Conclusion of lawsuit**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 8/7/08
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Abraham Morrison	8/18/1967	073-44-7923
Patient Address: **c/o Calvary Hospital, 1740 Eastchester Road, Room 642, Bronx, NY 10461**		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Dr Patrick Dalton, 99 University Ave. New York, NY 10003

8. Name and address of person(s) or category of person to whom this information will be sent:
Gairson McCarthy, LLC 26 Broadway Suite 2400, New York, NY 10004

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- AM **Alcohol/Drug Treatment**
- AM **Mental Health Information**
- AM **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here AM (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:
Alexandra Mishail, Esq., and/or Paul E. Kerson, Esq., of the law offices of Leavitt, Kerson & Duane
(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**Conclusion of lawsuit**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 8/7/08
Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Abraham Morrison	8/18/1967	073-44-7923

Patient Address

c/o Calvary Hospital, 1740 Eastchester Road, Room 642, Bronx, NY 10461

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Dr. William Grack, 36 7th Ave, Suite 511, New York, NY 10011

8. Name and address of person(s) or category of person to whom this information will be sent:
Brayton McCarthy LLC, 26 Broadway, Suite 2400, New York, NY 10004

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

- ___ **Alcohol/Drug Treatment**
- ___ **Mental Health Information**
- ___ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here SAM (Initials) I authorize _____ (Name of individual health care provider)

to discuss my health information with my attorney, or a governmental agency, listed here:

Alexandra Mishail, Esq., and/or Paul E. Kerson, Esq., of the law offices of Leavitt, Kerson & Duane

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ☐ Other:	**Conclusion of lawsuit**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: 8/7/08

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name	Date of Birth	Social Security Number
Abraham Morrison	8/15/1967	073-44-7923

Patient Address

c/o Calvary Hospital, 1740 Eastchester Road, Room 642, Bronx, NY 10461

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
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6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:
Calvary Hospital 1740 Eastchester Road, Bronx NY 10461

8. Name and address of person(s) or category of person to whom this information will be sent:
Bainton McCarthy LLC, 325 Broadway, Suite 2400, New York, NY 10007

9(a). Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ☐ Other: _____

Include: (*Indicate by Initialing*)

AM **Alcohol/Drug Treatment**
AM **Mental Health Information**
_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ☑ By initialing here AM (Initials) I authorize _____ (Name of individual health care provider)

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Alexandra Mishail, Esq., and/or Paul E. Kerson, Esq., of the law offices of Leavitt, Kerson & Duane
(Attorney/Firm Name or Governmental Agency Name)

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12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

Abraham Morrison
Signature of patient or representative authorized by law.

Date: 8/7/08

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